



Work Accident History

Please Print

Date: _____

Patient Information

Acct# _____

Dr. Mr. Mrs. Ms. Miss

Marital status: M S W D

Last Name _____ First Name _____ Middle Initial _____ Nick Name _____

Address _____ City _____ State _____ Zip Code _____

Home phone: _____ Mobile Phone: _____

Email address: _____

Social Security No.: _____ Date of Birth: _____ Sex: M F

Occupation (specific job title): _____ Employer: _____

Work Address: _____

Person to contact in an emergency: _____ Phone: _____

Employer Information

Company Name _____ Supervisor Name _____ Work Phone# _____

Address _____ City _____ State _____ Zip Code _____

Nature of business (eg., food manufacturing, building construction, retailer of women's clothes)

Insurance Information

If you have any insurance information please give it to the staff person assisting you.

Symtoms

1. Date of Accident/Injury: _____ Gradual Sudden Progressive

2. Address/location where you were injured: _____

No. and Street _____ City _____ County _____

3. Time of day when accident occurred: _____ am/pm Date last worked: _____

4. Did you report this to you employer? Y N If so, to whom? _____

5. Did you go to the hospital or another doctor's office after the accident? Y N

If so, where: _____ Were X-rays taken? Y N

What type of treatment was administered? _____

Was a diagnosis made? Y N If so, what was it? _____

6. Describe how the accident/injury happened: _____

7. What is your **number-one** problem or the **one area** of greatest pain? _____

8. Have you ever experienced this problem before? Y N When? _____

9. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

10. How often do you experience the pain?

- 1-2 hours per day About half of the day Most of the day The pain never goes away

11. How does the pain effect your daily activities?

- It does not effect my daily work or home activities.
 I have had to change how I do my work or home activities. Explain: _____
 I cannot do the following due to my present problem: _____
 I am unable to do nearly everything I am accustomed to doing.

12. What **increases** your pain? _____

13. What **decreases** your pain? _____

14. List any other complaints currently bothering you and rate your pain level for each.

- a. _____ 0 1 2 3 4 5 6 7 8 9 10
b. _____ 0 1 2 3 4 5 6 7 8 9 10
c. _____ 0 1 2 3 4 5 6 7 8 9 10
d. _____ 0 1 2 3 4 5 6 7 8 9 10

15. Do you feel you could perform your usual job right now? Y N

16. Describe your routine job duties: _____

17. If you are working, how has your current condition affected your normal duties? _____

18. Is there any activity or duty you are unable to perform? _____

19. How often does your job require you to do the following:

- Lifting (_____ lbs)
 Sitting (_____ hrs/day)
 Standing (_____ hrs/day)
 Computer (_____ hrs/day)
 Telephone (_____ hrs/day)
 Driving (_____ hrs/day)
 Push/pull: Once in a while Often Frequently Almost all the time
 Reach overhead: Once in a while Often Frequently Almost all the time
 Grasping: Once in a while Often Frequently Almost all the time
 Twisting/bending: Once in a while Often Frequently Almost all the time
 Squatting/kneel: Once in a while Often Frequently Almost all the time
 Walking: Once in a while Often Frequently Almost all the time
 Climbing/ladders: Once in a while Often Frequently Almost all the time
 Other Please explain: _____

20. Have you ever been injured at work prior to this accident/injury? **Y** **N** When? _____
Please explain: _____
21. Have you ever been involved in an automobile accident before? **Y** **N** When? _____
Were you injured? **Y** **N** Please explain: _____
22. List all medication you are currently taking (prescribed and over the counter) _____

23. List all surgeries you have had (with date) _____

24. Please provide your medical doctors name _____

25. Please provide any previous chiropractors you have treated with _____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="radio"/> heart attack | <input type="radio"/> stroke | <input type="radio"/> arthritis | <input type="radio"/> gall bladder trouble |
| <input type="radio"/> diabetes | <input type="radio"/> glaucoma | <input type="radio"/> fainting spells | <input type="radio"/> kidney stones |
| <input type="radio"/> bloody stools | <input type="radio"/> cancer | <input type="radio"/> asthma | <input type="radio"/> difficulty with urination |
| <input type="radio"/> prostate trouble | <input type="radio"/> anemia | <input type="radio"/> AIDS | <input type="radio"/> ulcers |
| <input type="radio"/> diverticulitis | <input type="radio"/> dizziness | <input type="radio"/> chest pain | <input type="radio"/> menstrual cramping |
| <input type="radio"/> loss of memory | <input type="radio"/> constipation | <input type="radio"/> diarrhea | <input type="radio"/> shortness of breath |
| <input type="radio"/> general fatigue | <input type="radio"/> nausea | <input type="radio"/> muscle cramping | <input type="radio"/> sudden weight loss |
| <input type="radio"/> ears ringing | <input type="radio"/> headache | <input type="radio"/> soreness in joints | <input type="radio"/> loss of hearing |
| <input type="radio"/> migraine | <input type="radio"/> epilepsy | <input type="radio"/> gout | <input type="radio"/> tuberculosis |
| <input type="radio"/> syphilis | <input type="radio"/> knee/hip replacement | <input type="radio"/> sprained ankle [] R [] L | |
| <input type="radio"/> difficulty with bowel movements | <input type="radio"/> broken bones(specify) _____ | | |

General Activities (check all that apply)

- | | | |
|---|--|--|
| <input type="radio"/> sleep on waterbed | <input type="radio"/> read in bed | <input type="radio"/> fall asleep in recliner/on couch |
| <input type="radio"/> sleep on stomach | <input type="radio"/> needlepoint/knitting | <input type="radio"/> use two or more pillows to sleep |
| <input type="radio"/> sewing | <input type="radio"/> lift weights.wt. mach. | <input type="radio"/> play video games(___hrs per week) |
| <input type="radio"/> jog___x/wk | <input type="radio"/> swim | <input type="radio"/> computer use (___hrs per week) |
| <input type="radio"/> exercise___x/wk | <input type="radio"/> use treadmill | <input type="radio"/> watch Television (___hrs per week) |

Please add anything else you would like the doctor to know: _____

